



**DEPENDENT CARE ASSISTANCE PROGRAM (DCAP)
REIMBURSEMENT CLAIM FORM**

EMPLOYER NAME

Commonwealth of Massachusetts

EMPLOYEE INFORMATION

| | | | |
|----------------|------------|------------------------|--|
| LAST NAME | FIRST NAME | MIDDLE INITIAL | PHONE # |
| STREET ADDRESS | | SOCIAL SECURITY NUMBER | |
| CITY | STATE | ZIP | <input type="checkbox"/> CHECK IF ADDRESS CHANGE |

INSTRUCTIONS

- 1) Complete the above information; please print. See reverse for additional instructions
- 2) Enter your expenses below
- 3) Complete additional information for dependent care expenses
- 4) Sign and date
- 5) Attach receipts to this form and mail or fax to

SENTINEL BENEFITS
601 Edgewater Drive, Suite 250
P.O. Box 4072
Wakefield, MA 01880
800.819.9833 Fax. 781.213.7301



DEPENDENT CARE CLAIM INFORMATION

| | Date(s) of Service | Provider of Service | Receiver of Benefit Child or Dependent | Amount Requested |
|---|--------------------|---------------------|---|---------------------|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

Total Reimbursement
Requested

| |
|--|
| |
|--|

ADDITIONAL INFORMATION FOR DEPENDENT CARE EXPENSES

| Dependent's Name | Relationship | Birth Date | Individual or Institution to which Dependent Care Expenses Were Paid |
|------------------|--------------|------------|---|
| | | | NAME |
| | | | ADDRESS/CITY/STATE |

SIGNATURE OF PROVIDER _____ SSN OR TAX ID _____

**PROVIDE A CANCELLED
CHECK OR RECEIPT**

CERTIFICATION

I request payment from my reimbursement account for the expenses itemized above. I certify that I have not requested reimbursement under this plan or from any other source for these expenses. I also certify that the total dependent care expenses for which I am requesting this plan year do not exceed the lesser of my or my spouses earned income for the year. I further certify that I have met all of the requirements for eligible dependent care expenses as described on the reverse side of this form. I understand that reimbursement expenses cannot be claimed on my personal income tax return.

SIGNATURE _____ DATE: _____

Check out your account balances on-line at www.myfsa.com

IMPORTANT INFORMATION REGARDING DEPENDENT CARE REIMBURSEMENTS

DEPENDENT CARE ELIGIBLE EXPENSES: In general, the following rules apply to dependent care expenses:

No participant shall be allowed to defer more than \$5,000, if married filing jointly, or \$2,500 if married filing separately. The maximum that can be deferred under this program shall be the lesser of \$5,000 or the earned income of the participant's spouse.

The expenses must be employment-related expenses for the care of a dependent of the employee who's entitled to a dependent deduction under the Internal Revenue Code Section 151(e). This includes children under the age of 13 and any other IRS dependent, regardless of age, who is mentally or physically incapable of caring for him/herself.

Payments cannot be made to a person who is claimed as a dependent by the employee.

If the services are provided by a day care center which provides care for more than six individuals, the center must comply with state and local laws.

SUPPORTING DOCUMENTATION: The following supporting documentation must be attached to this form:

Dependent Care Expenses: Complete the requested additional information for dependent care expenses on the front of this form. Please do **one** of the following: Ensure that the Care Giver signs the front of this form, or attach a cancelled check, or attach a receipt from the Care Giver if one exists. If services are provided by a Care Center please provide the Tax ID#, or, if an individual provide their Social Security Number.

DEPENDENT CARE ELIGIBLE EXPENSES:

Eligible Expenses under a Dependent Care Assistance Plan

Eligible expenses under a Dependent Care Assistance Plan are defined as those that enable the participant and the participant's spouse to work or to look for work. They include the following:

1. Child care centers that care for six or more children and that meet the IRS's definition of a qualified day care center;
2. Caregivers for a disabled spouse or dependent who lives with the participant;
3. Babysitters;
4. Nursery schools;
5. Day Camp; and
6. Household expenses, provided that a portion of such expenses are incurred to ensure a qualifying dependent's well-being and protection.

Note: In compliance with the IRS guidelines, the service provider cannot be an individual for whom a personal tax exemption may be claimed. In addition, a child of the participant or spouse cannot be under the age of 19.

Ineligible Expenses under a Dependent Care Assistance Plan

1. Babysitting for social events;
2. Educational expenses; and
3. Charges for overnight camp.